STATE OF MICHIGAN
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
PUBLIC HEARING – MISCELLANEOUS CON REVIEW STANDARDS
Friday, October 17, 2003
Lewis Cass Building
320 South Walnut
Lansing MI

Neonatal Intensive Care Services/Beds
Open Heart Surgery Services
Cardiac Catheterization Services
Pancreas Transplantation Services
Air Ambulance Services
Psychiatric Beds/Services
Heart/Lung & Liver Transplantation Services
Magnetic Resonance Imaging (MRI) Services
Nursing Home & Hospital Long-Term-Care (HLTC) Unit Beds
Positron Emission Tomography (PET) Scanner Services
Bone Marrow Transplantation Services

ORAL TESTIMONY

Approximately 20 people in attendance

(Proceedings scheduled to start at 10:00 a.m.; actual start time was 10:07 a.m.)

MS. ROGERS: Good morning. My name is Brenda Rogers. I am special assistant to the Certificate of Need Commission from the Department of Community Health. Chairperson Renee Turner-Bailey has asked the Department to conduct today's hearing. We are here today to take testimony concerning potential language revisions to the following Certificate of Need Review Standards: Neonatal Intensive Care Services/Beds; Open Heart Surgery Services; Cardiac Catheterization Services; Pancreas Transplantation Services; Air Ambulance Services; Psychiatric Bed/Services; Heart/Lung & Liver Transplantation Services; Magnetic Resonance Imaging Services; Nursing Home and Hospital Long-Term-Care Unit Beds; Positron Emission Tomography Services; and Bone Marrow Transplantation Services.

The proposed language changes to the above mentioned CON Review Standards relate to Medicaid requirements under PA 619 of 2002 as well as other technical changes. Please be sure that you have signed the sign-in log. Copies of the proposed changes to each review standard can be found on the table. Comment cards can be found on the table too and need to be completed if you wish to provide testimony. Multiple review standards may be identified on one comment card; however, we will hear testimony on one review standard at a time. Please hand your card to me if you wish to speak, and print your name on the sign-in sheet located at the podium. Additionally, if you have written testimony, please provide a copy as well. As indicated on the Notice of Public Hearing, written testimony may be provided to the Department through October 24, 2003, at 5:00 p.m.

We will begin the hearing by taking testimony from those of you who wish to speak. The hearing will continue until all testimony has been given, at which time we will adjourn. Today is Friday, October 17th, 2003, and we are now taking testimony. Neonatal Intensive Care Services, I have Bob Meeker from Spectrum Health.

MR. MEEKER: My name is Bob Meeker from Spectrum Health, and I will have essentially the same comments on all the standards, so I will be much briefer next time I come up here. I have not had an opportunity to review the specific language for each and every standard. If I have any comments on those, we will provide those as written comments. My oral comments relate to the requirement for Medicaid participation by all CON holders.

Spectrum Health has and continues to strongly support this provision within the Certificate of Need and furthermore would like to see the standards, as worded, strengthened; we'll be working on language that might do that, but, you know, some requirement that the CON holder not only provide proof of Medicaid participation, but rather participation at a level commensurate with the Medicaid need within the community. And I think it's important that access be provided to this, the very neediest of members of our communities, and that the responsibility for providing services to that population be spread equally over all providers within the community.

MS. ROGERS: Thank you. Any other comments regarding NICU? Hearing none, we move to Open Heart Surgery Services. Again, Bob Meeker, Spectrum Health.

MR. MEEKER: Bob Meeker, Spectrum Health. We support Medicaid participation and will work on language to strengthen it so that it requires equal participation in Medicaid of all providers in the community.

MS. ROGERS: Thank you. Dan Hatton, Bay Regional Medical Center.

MR. HATTON: Good morning. I'd like to address my comments regarding the standards for open-heart surgery and suggest an adjustment to the standards. And it started with primary percutaneous coronary intervention, PCI. Putting aside my personal bias regarding PCI or primary angioplasty and postulating that primary angioplasty advocates will be successful in their attempt to be recognized in Michigan, I wanted to discuss some options as a result. Primary percutaneous coronary intervention will change everything. It will have a negative effect on the practice of open-heart surgery in Michigan. Increasing the numbers of hospitals who have permission to perform PCI will decrease the potential number of open-heart surgeries that are performed. The simple fact is that if the patient undergoes primary angioplasty, then that will translate in most cases to one less open-heart surgery somewhere in Michigan.

The cardiology roundtable: And according to the cardiology roundtable, the number of open-heart surgeries decreased nationally five to ten percent, and they expect that trend to continue. Recently West Virginia and Florida lowered their CON targets for open-heart surgery, and they further note the explosive growth in what Michigan terms "therapeutic cardiac catheterizations."

The role of the physicians: You see, the cardiologist places the stent and performs the PCI. The cardio thoracic or cardiovascular surgeon does not. The patient sees and talks with the cardiologist first, and the conversation goes something like this: "Patient, you essentially have two choices: I can refer you to a surgeon who will rip your chest open, take a vein from another part of your body and bypass the blockage, or I can place this tiny stent in your artery, and you will be back to work in two to four weeks." Which option would you choose if given the choice? The patient is left with the option of, "Do I want to join the 'zipper club' or not?" The world of cardiology is quickly moving toward stenting first and cardiac surgery second.

Another factor in this discussion is that the cardiac surgeons perform open-heart surgery; hospitals do not. However, the hospital had MDCH performance criteria placed on them. I fully

support MDCH quality criteria which now places more emphasis on reviewing and examining physician activity in the specialty. In this case, in the case of Bay Regional Medical Center, the same group of cardio thoracic and vascular surgeons practice at St. Mary's Medical Center and Covenant Hospital.

Technology trends: When one examines the report which is distributed practically at every Certificate of Need Commission meeting since 1999 entitled "Pre-Market Approval Decisions," one quickly notices the trend of the "stent-of-the-week club," whereas the only significant improvement in the field of open heart surgery has been the off-pump procedure. I believe this trend coupled with the primary angioplasty movement will place existing open-heart programs in Michigan in jeopardy and will create unnecessary volume problems. Unlike the primary angioplasty supporters, I believe that both angioplasty and open-heart surgery are linked both clinically and from a patient's safety perspective.

The State of Michigan specifically and deliberately links the clinical procedures of open-heart surgery and therapeutic cardiac catheterization in their current CON standards. A hospital cannot have one without the other. The passage of primary PCI begins to make what was once a very clear distinction now a fuzzy one. However, trends are trends, and how does one make appropriate adjustment for these trends?

The suggested proposal is this: Now that primary angioplasty supporters have been successful, I believe that some accommodation must be made for existing open-heart surgery programs. My suggestion is this: The maintenance of the 200 to 300 open heart surgeries and the 300 therapeutic cardiac catheterizations are eliminated and replaced with a formula that takes 50 percent of the combined total of open heart surgeries and therapeutic cardiac catheterizations stenting angioplasty procedures. The total would have to be a minimum of 450. Diagnostic cardiac catheterizations would be excluded. Entry-level criteria are excluded. They would still remain in effect; hence, a hospital, which performed 300 surgeries, and 800 stenting/angioplasty procedures would have a CON equivalent of 550. 300 plus 800 equals 1100, divided by 2 equals 550 as their official MDCH reported total and would meet the minimum revised standard of 450. Thank you.

MS. ROGERS: Thank you. Do we have any further testimony regarding Open Heart Surgery Services? For those of you that just arrived, we are taking comment on each standard one at a time. We've just completed Open Heart Surgery. I will back up to NICU if anybody that walked in would like to provide testimony on NICU. Hearing none, we move to Cardiac Catheterization Services. I have Bob Meeker, Spectrum Health.

MR. MEEKER: I'm Bob Meeker with Spectrum Health. Spectrum Health strongly supports Medicaid participation as a requirement for CON, and we will be working on language to strengthen that provision to require applicants to participate at a level commensurate with the need in the community.

MS. ROGERS: Thank you. Any further testimony on Cardiac Catheterization? Hearing none, we will move to Pancreas Transplantation Services. Mr. Meeker?

MR. MEEKER: Is there any way you can just ask her to duplicate my comments?

MS. ROGERS: Since Mr. Meeker's comments will be the same for all, let's just make a notation that he supports the Medicaid language for all of the CON Services identified here today. Next up is Air Ambulance Services. Do we have any testimony for Air Ambulance?

Moving along, Psychiatric Beds and Services. Heart/Lung and Liver Transplantation Services, any testimony? MRI, Magnetic Resonance Imaging Services? Nursing Home and Hospital Long-Term-Care, I have one card for that. Pat Anderson?

MS. ANDERSON: I'm Pat Anderson. I'm the Assistant Vice President of Reimbursement for the Health Care Association of Michigan. And I have written comments I'll submit to you. We did review the standard, the technical changes, and I had one comment on them. There's one section in Section 11 on the project requirements. We were unsure what that meant. It's got an item there; it says they should not deny services to any individual based on ability to pay or source of payment. I do not know if that meant that the facilities were all supposed to provide charity or uncompensated care, so we questioned that. In Michigan the county medical care facilities, under their design, are supposed to provide that care and then their funding under the Hill-Burton Organization. So we were concerned about that, and I've highlighted that at the end.

The other, what we wanted to do –- and I don't know if this is appropriate or not, but I'll bring it in anyway. We had a couple other suggestions for changes to the review standards that would allow a greater flexibility within the systems to allow nursing facilities to be able to replace their structures and to accommodate the needs of the residents they have. Right now, just to give everybody a little point of reference, the nursing facilities in Michigan were primarily built from about '65 to '75, and a lot of those facilities, as Medicaid and Medicare became programs then, were conversions of old buildings, hotels. All sorts of buildings were converted to nursing homes. A lot were built then. But that means our buildings are 30-plus years old. They're very old facilities. We need to make changes.

What we would like to do is to be able to allow more flexibility in making those changes to our structures and to be able to meet the customers' needs. The customer nowadays has much more health needs and also is requesting that they don't have to have roommates anymore, providing single-occupancy rooms, providing a home-like environment for them. So what we would like to recommend for CON changes is for Review Standard Section 2 entitled "Definition of Replacement Zone," that for –- it says for a county that is not a rural county, you have to be within the three-mile radius of the existing licensed site. We'd like to drop the "three-mile radius" to do within the planning area.

In CON Standard Section 7, "Title Requirements for Projects Involving New Construction," it requires in there that you cannot build a facility that is greater than 450 gross square feet per individual. Most new constructions now are between 600 and 700 square feet. That doesn't mean someone gets a room that's 400 square feet. This includes all of the activity areas and everything. This reference to the 450 maximum square feet is also contrary to the design standards that Consumer and Industry Services provides. So we'd like the -- the minimum is terrific, and no one usually does the minimum, but the maximum seems inappropriate at this time.

The other is Section 8 entitled, "Requirements for Approval of Replacement Beds." We'd like to be able to lighten it up so that if facilities have a number of beds that they would like to transfer to build a new facility, thus making both facilities more accommodating for residents, that they are able to transfer part of that license to a new structure. Under the current rules, they aren't allowed to do that. That may also require a change in what they call a licensed site. These like I said, would add a degree of flexibility to help us start replacing. None of these changes would require increase in the number of nursing home beds, and we're not asking for a change in that or the bed-need methodology.

MS. ROGERS: Thank you. Any further testimony on Nursing Home Beds? We'll move to PET Scanner Services, and I have Monica Harrison with Oakwood.

MS. HARRISON: My name is Monica Harrison, and I'm System Planner for Oakwood Health Care System in Dearborn. Currently PET CON Review Standards do not allow an existing machine with excess capacity on a mobile route to be utilized at existing host sites on different routes. This restriction of service creates undue operational and financial hardships and propagates the creation of unnecessary new routes, which cost in excess of two million each; however, the mobile MRI standards do allow this flexibility in service, and this has served the state very well. We would recommend that to ensure uniformity across the mobile services standards that central service coordinators should be allowed to provide service at any approved host site under the same guidelines presently used in the MRI standards. This accommodation would ensure the most efficient utilization of PET Service within the state.

The standards also state that 85 percent of the route's actual volumes are to come from the planning area from which the data was committed. The standards do not specifically address host site applications in regard to planning areas or volumes. The onus is placed upon the central service coordinator as the only entity subject to volume review. Language that delineates host site application and compliance standards would be helpful to MDCH and all future applicants. Thank you.

MS. ROGERS: Thank you. Greg Dobis, McLaren HealthCare.

MR. DOBIS: My name is Greg Dobis representing McLaren Health Care Corporation out of Flint, and I would just like to support Oakwood's statements on the current situation with the PET scanner, being it's placing an undue hardship on ramp-up time for the PET scanner trying to lease out unused days to other hospitals who have a definite interest and have approached central service coordinators such as McLaren to lease those days out. Due to the current standards, we are unable to do that.

Also, in addition, we cannot adequately serve one of the other hospitals within one of our other affiliates within our corporation. Because of the 85 percent ruling, which we call the 85/15 rule, we are prohibited to fully servicing Ingham Regional Medical Center, one of our affiliates, and that also places undue hardship, seeing Ingham has committed 100 percent of their both cancer and heart as well as epilepsy cases to the central service coordinator which is McLaren Health Care Corp. And we would like to see that revisited to determine if there's a more fair or equitable way or 100 percent and just delete the 85/15 ruling.

MS. ROGERS: Thank you. Any further testimony regarding PET Scanner Services? Bone Marrow Transplantation Services, would anybody like to provide testimony? Hearing none, that's all of the CON Review Standards. For those of you that came in late that I maybe didn't receive a card from, is there anybody that wishes to provide any additional testimony on any of the standards? All right. Hearing none, it is 10:29 a.m. and this hearing is adjourned. Thank you.

(Proceedings concluded at approximately 10:29 a.m.)